Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 01/26/01?

   b. The request was received on 01/25/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/07/01
   b. HCFA's
   c. EOB
   d. Extended list of reimbursements from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 03/18/02
   b. HCFA's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. There was not a sign sheet in the dispute packet. The 14 day response from the Provider was received by the Carrier on 03/08/02 and the response from the insurance carrier was received in the Division on 03/18/02. Based on 133.307 (i) the insurance carrier's response is timely.

III. PARTIES' POSITIONS

1. Requestor:

   a. The Provider... "Charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services." The provider is seeking additional reimbursement in the amount of $3,558.44 for the date of service 01/26/01.

2. Respondent:

   a. "In a nutshell, Claimant had nerve blocks on DOS (1/26/01) in question. First, the provider failed to include EOBs and documentary support for its position that the price charged is fair and reasonable. As such, the Request is incomplete and must be deemed "not filed' until such time as it is filed in the form required by the TWCC under TWCC Rule 133.305. Second, Carrier also asserts that the amount it paid for all CPT Codes on the DOS in question is fair and reasonable and in accordance with all TWCC rules and procedures." The carrier denies additional reimbursement as M-"IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/26/01.

2. The provider billed $4,676.44 for date of service 01/26/01.

3. The carrier paid $1,118.00 for date of service 01/26/01.

4. The amount in dispute is $3,558.44 for date of service 01/26/01.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Per the UB-92 submitted in the original packet, the Requestor billed the ICD-9 code of 723.1 which is Cervicalgia. The medical reports indicate that the services were performed. The provider submitted an extended list of reimbursements from other carriers without any identifying ICD-9 codes showing similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf to demonstrate payments for fair and reasonable. The provider has also submitted EOBs from one carrier; these indicate reimbursements from a range of $2,236.00 to $3,235.50. The EOBs submitted do not reflect any ICD-9 codes. Documentation is insufficient to determine if the charge of the Requestor is fair and reasonable. This does not conform with the criteria in Sec. 413.011 (d). Therefore, additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 21st day of May 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.